

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize _____
To disclose health information in the medical records:

_____ BD: _____ SS#: _____
(PRINT name of patient)

Information to be sent to:

Name of designated recipient

Address

City, State, Zip Code _____
Phone Number

Information to be released:

____ Progress Notes ____ EKG's ____ Immunizations
____ Lab Reports ____ Problem List ____ Consultations
____ Radiology Reports ____ Medication List ____ Accounting of Disclosure
____ Other (please specify) _____
____ **All health care information**

Specify date(s) of treatment requested: _____

Purpose for which disclosure is being made: (Please check one of the following)

____ Attorney ____ Insurance ____ Doctor ____ Personal

Patient Authorization:

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted diseases, drug and or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

EXCLUDE the following information from the records released (please initial)

____ Drug/Alcohol abuse/treatment & diagnosis ____ Sexually Transmitted Infections
____ HIV/AIDS diagnosis/treatment/testing ____ Mental Illness

My Rights

I understand I don not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign the authorization form:

- To take part in a research study or
- To receive health care when the purpose is to create health information for a third party.

I may revoke the authorization in writing. To review the process for revoking the authorization, please read the Privacy Notice to our patients. I understand that once Yakima Medical Clinic discloses health information, the person or organization that receives it may re-disclose it, at which time it may no longer be protected under Privacy laws.

SIGNATURE _____ DATE _____
(Patient, Guardian*, or Authorized Representative*)

(Please provide documents to prove authority to sign on behalf of the patient)

This authorization will expire 90 days from the date signed. Possible copying fee required
If you desire a copy of this authorization, please nifty a representative of the medical records department upon completion of this form.